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BRIEF TO THE ONTARIO MEDICAL SERVICES INSURANCE ENQUIRY

FROM: The Ontario Association of Social Workers,
Room 201, 160 Bay Street,
Toronto 1, Ontario.

INTRODUCTION

1. The Government of Ontario is to be commended for its recognition of the need for health services, and for its further recognition of the importance of public opinion on this matter, as evidenced by the establishment of the Medical Services Insurance Enquiry. The Ontario Association of Social Workers welcomes this opportunity to submit the views of its members on the proposed Medical Services Insurance legislation.

2. The Ontario Association of Social Workers includes in its membership 1016 professional social workers in Ontario. Our provincial organization is affiliated with the national organization, The Canadian Association of Social Workers, which adopted in 1962 a position with respect to health care for Canadians.[1] The Brief of the Association presented to the Royal Commission on Health Services in 1962 outlines the professional concern of social workers in the provision of Health Services and delineates the principles we believe to be essential in planning and providing health care in Canada.

3. Members of the Association, through employment in government departments at all levels, private social agencies, public and private hospitals and treatment institutions, encounter daily the social and emotional consequences of illness, as experienced by persons who are sick or disabled, their families and relatives, and the communities in which they live. Our professional concern is for the social, physical and emotional well-being of all people and we hope that our knowledge and the experience gained in helping numerous people with their social problems will prove useful to the Enquiry in its deliberations.

[1] See Appendix

Shall there be a board, separate from Medical Carriers, responsible for administering Govt. ou Board policy? } vague about it but answer yes

4. As stated in the National brief, social workers support the democratic philosophy that every person should have the opportunity to develop to his full potential and to make his most effective contribution as a member of society. We agree that physical and mental health is essential and that all people suffering from ill health should have the opportunity for the medical care appropriate to their physical and mental conditions. We know that good health is costly but we consider that the poor health of its people is even more costly to society. We can not approve of the provision of health care through a health plan which divides the nation into first class and second class citizens on the basis of their ability to pay individually for the medical care they need.

5. We maintain therefore:

(1) That society has the responsibility of ensuring that the opportunity for adequate health care is provided to all its members.

(2) That a plan to provide comprehensive health service should be established.

(3) That there should be no difference in the kind, quality or form of care available under the plan based on the ability of the patient to pay.

(4) That universal coverage is essential. One of the reasons for recommending a government-administered plan financed from taxes is that it would achieve our goal of universal coverage. We recognize that if the plan is administered provincially flexibility in the method of financing may be necessary as in Hospital Insurance. We would hope that such flexibility might be regarded as a stage in development toward the goals of a tax supported program.

(5) That the services should be available to all persons domiciled in Canada without distinction. We recognize that a plan for one province cannot fully achieve this objective but it should come as close as possible to doing so.

(6) That the plan should be administered in such a way as to provide citizen participation in the policy-making body. While medical decisions must be left to the medical profession, provision should be made for participation in policy-making of the citizens of the country. The consumers of health care have a right to be represented in the administrative body.

6. In preparing our position the members of the Association recognized that while a comprehensive plan for health services is necessary, it may initially only be possible to implement the plan in part. Any step in this direction would be welcomed and supported by the members of the Association.

7. Although the Act calls for a different method of providing medical services than our Association recommended we have carefully studied the legislation to determine how far it goes in achieving the goals we believe to be essential. In examining the Act against the background of these goals we see definite weaknesses and limitations which are commented on below. In our opinion the proposed legislation does not provide a significant stage toward the achievement of adequate health services for the people of Ontario, nor is it designed as part of a comprehensive plan.

UNIVERSAL COVERAGE

8. The proposed coverage is permissive both with respect to those who elect to purchase medical insurance and those for whom the provincial or municipal governments may purchase insurance. It is not possible to determine from the provisions of the Act the extent to which the proposed legislation will provide

for the medically indigent. Permissive provision is made for the government to purchase standard medical services insurance on behalf of the recipients of the various income maintenance programs providing they are "needy". Additionally the government may elect to contribute to the cost of standard medical services insurance for other unspecified groups of "needy persons". Lacking a definition of "needy persons" it is not possible to estimate how many people might qualify for assistance in meeting the costs of insurance but we anticipate the number would be large, and the administration of this provision would be both difficult and costly. It would not be possible to identify "needy persons" on the basis of a means test - that is on the basis of the family or individual income. A needs test, administratively much more difficult, would be necessary to identify those who are actually medically indigent. Account would have to be taken of the fact that the costs of medical care not covered by the insurance plan, (drugs, appliances, nursing, physiotherapy and homemaking services, etc.), could run very high. Many people, even though assisted in meeting premium costs, will not be able to profit by the insurance coverage unless provision is made to cover the costs of essential excluded services which they are not themselves able to meet. For the medically indigent some immediate provision for these related costs is necessary until such time as they may be incorporated in an expanded insurance program.

9. It should be recognized that the recipients of public assistance on whose behalf the government may elect to purchase insurance, are, in very substantial measure, already receiving medical services (equivalent to that proposed by the legislation) through the Ontario Medical Welfare Plan and the free services available to them as public patients. It is the low and moderate income family or individual not dependent on public welfare who would be least served by this plan. In our opinion, universal coverage, even within the limited scope of the proposed medical insurance, is not assured.

FINANCING MEDICAL INSURANCE

10. The Act provides for extension of coverage in the "standard medical insurance contract" to certain high risk categories excluded from most presently available voluntary insurance plans and guarantees that contracts will be renewable. While our Association believes that medical services should be available to all who need them, we anticipate that this extended coverage will increase premium rates beyond those presently in effect. Profits are an accepted cost of operation for commercial insurance companies and would be reflected in higher premium costs. We are concerned that no limit is set by the Act on profits except through competition. Further, premiums will be weighted by medical fee schedules and the Ontario Medical Association has been given monopolistic control in setting these. The final decision on premium rates is placed by the Act in the hands of one government official subject to majority decision of a board of three arbitrators, two of whom are to be named by insurers (one of accident and illness insurance, the second by other insurers). Present premium rates of the non-profit insurance companies are already out of reach of many employed persons unless the cost is being shared by their employers. With the anticipated increased cost in premiums we believe a significant number of additional families would be unable to purchase insurance at the same time having no assurance of government subsidy to meet this cost. Those persons whose employers do not contribute to premium costs will be penalized as well as those with no employers, (i.e. self-employed, retired).

CONTINUITY OF COVERAGE

11. The Legislation imposes a number of limitations which mitigate against continuity of coverage; the frequency of open enrolment periods is not specified, applications outside regular enrolment periods are subject to late enrolment fees and delayed benefits for periods of 3 or 10 months. Residence requirements

are a further limiting factor. We believe that many families in our mobile society whose incomes are depleted through periods of unemployment would be adversely affected by these limitations and that those whose need for coverage is greatest will not have continuity of coverage.

CITIZEN PARTICIPATION IN THE POLICY-MAKING BODY

12. We cannot determine from the wording of the Act (as in Section 8-(4) and 18-(2)), whether or not the policy holders are represented, but maintain that they should be. It appears that policy, part from premium rates which are subject to arbitration, would be determined by "Medical Carriers Incorporated". The proposed legislation should provide for consumer representation on the policy-making body.

CONCLUSION

13. On the basis of our evaluation we can only conclude that apart from bringing some uniformity and control to those companies selling medical insurance, the proposed legislation does little to achieve the goals of this Association for adequate health services for Canadians. More immediately, it does not, in our judgement, increase the availability of health care for the needy groups on whose behalf insurance will be purchased by the government. Further, the number of families who cannot now afford to purchase medical insurance, will, we believe, be even greater when anticipated increases in premium rates become effective.

14. We assume that the Provincial Government, in appointing this Medical Services Insurance Enquiry, is planning to make changes in the legislation in the light of these hearings. We sincerely hope that serious consideration will be given to the points raised by our Association.

Brief to
Royal Commission
on Health Services

MAY 1962

Canadian Association of Social Workers
Association Canadienne des Travailleurs Sociaux

18 Rideau Street

OTTAWA Canada.

Brief to the Royal Commission on Health Services

SUMMARY OF RECOMMENDATIONS.

The Canadian Association of Social Workers, in the accompanying submission, makes recommendations to the Royal Commission on Health Services under the following headings :

I. The Contribution of the Social Worker to Medical Care

"That the Royal Commission recognize that :

i) a Social Service Department is an essential part of a hospital or medical treatment institution, whenever that institution is sufficiently large to support the service;

ii) to give effective service, such Departments should be staffed by professionally qualified social workers;

iii) the appointment of social workers to county health units should be encouraged to supply professional service in small hospitals, to assist with the social problems of ill people in their own homes, and to facilitate the movement of persons to and from medical centres when this is necessary;

iv) many patients receiving medical care from private practitioners do not have available to them, the services of professional social workers, and as social problems related to illness are not confined to persons requiring hospital or institutional treatment, the medical practitioners should be encouraged to make use of social workers attached to public and private community agencies when their patients need the help of a social worker."

II. The Interdependence of Health and Welfare Services

"That the Royal Commission recognize that :

i) a national health program will be limited in its effectiveness unless the supporting welfare services are also strengthened. This means the development of new services, in some instances, such as the provision for loss of income due to the illness of the breadwinner; in other instances, it means the expansion of services now available

in some communities to other areas, or their expansion within a community to make adequate provision: for example, convalescent hospitals, homemaker services, or the provision of prosthetic appliances;

ii) the close co-ordination of health and welfare services is necessary if the provision of medical care is to be effective in developing a physically and mentally healthy population;

iii) the pattern of services must be dictated by varied needs of sick people, and not be compartmentalized for the sake of apparent administrative simplicity."

III. A National Program for Personal Health Care

"We therefore recommend to the Commission that:

i) the government should establish a program to make available to all persons living in Canada, comprehensive health services;

ii) the program be financed by taxes;

iii) the services be available to all persons domiciled in Canada without distinction;

iv) the plan be administered in such a way as to provide adequate citizen participation in the policy-making body;

v) the plan not to include deterrent payments or co-insurance."

IV. The Shortage of Social Workers

"We therefore recommend:

i) That the Commission adds its support to the representations already made to the federal government, that welfare training grants be made available to assist students to undertake professional training in social work, and to extend the facilities of the Schools to enable them to increase their enrolment."

BRIEF TO THE ROYAL COMMISSION ON HEALTH SERVICES

Introduction

The Canadian Association of Social Workers, the national professional organization representing 2600 social workers in Canada, welcomes the opportunity afforded by the appointment of a Royal Commission on Health Services to submit the views of its members on the important matters under study by the Commission.

Members of the Association, through employment in government departments at all levels, private social agencies, public and private hospitals and treatment institutions, encounter daily the social and emo-

tional consequences of illness, as experienced by persons who are sick or disabled, their families and relatives, and the communities in which they live. Our professional concern is for the social, physical and emotional well-being of all Canadians and we hope that our knowledge and the experience gained in helping numerous people with their social problems will prove useful to the Commission in its deliberations.

Our submission is presented in four sections :

I. The Contribution of the Social Worker to Medical Care

II. The Interdependence of Health and Welfare Programs

III. A National Program for Personal Health Care

IV. The Shortage of Social Workers.

I. The Contribution of the Social Worker to Medical Care

Social workers are employed in hospitals, clinics, and rehabilitation centres in which medical care is given to those suffering from physical or mental illness. The role of the social worker is to assist in the medical diagnosis and treatment, including rehabilitation, through his particular knowledge and skill in relation to social problems and relationships. He is one member of the team working to effect the return to health of the patient.

The Social Worker's Function

Some of the contributions which the social worker may make to the medical care of the patient are outlined below :

i) He contributes a social assessment to the diagnostic process, thus helping doctor or the clinical team make an accurate diagnosis, and determine the course of treatment. Some decisions regarding treatment such as home care or institutional care are dependent upon the social assessment.

ii) He assists patients and their families to overcome problems which prevent them from benefitting fully from medical treatment. These may relate to home responsibilities, attitudes to the illness, etc.

iii) He helps patients and their families to consolidate improvements achieved during treatment. He may, for example, give support to the discouraged patient, help the family recognize their role, help in the social adjustment.

iv) He helps patients and their families to remedy conditions contributing to illness. These conditions may be related to such matters as working conditions, housing, or family attitudes.

v) He acts as liaison between the medical facilities and the community services, bringing the latter to the service of the patient and his family, and sometimes helping to develop new resources in the community to meet the social need.

vi) He contributes as a consultant to the administration of the hospital or clinic in the formulation of policies affecting the social well-being of the patient.

vii) He undertakes to teach other hospital and health personnel so that their understanding of the social component in illness is broadened to enable them to participate more helpfully in the care and treatment of the patient.

viii) He engages in research related to the social aspects of illness or participates in research carried on by other departments.

In medical settings of all types, the social workers contribute to the purpose of the organization by working directly with the patient, and with his family, with community resources, and with other professional disciplines. As the social component in illness has become generally recognized, the contribution of the social worker in medical care has become increasingly important. He is employed not only in settings giving direct medical care, but also in health departments as a consultant on social problems, and community planning bodies seeking to improve and coordinate the services to sick and disabled persons. When the patient no longer requires direct medical care, but needs further help to re-adjust his attitudes, or his way of living because of the illness he has had, or the continuing disability, the social worker in the hospital refers him to professional colleagues in the community working under appropriate agencies. Similarly the hospital or clinic social worker may help workers in other agencies make the best use of the medical facilities available to those of their clients who require medical care.

Social workers in community agencies will in some instances be providing professional service to patients receiving medical care from private practitioners or from medical settings in which social workers are not available.

The Availability of Social Service Departments in Medical Care Facilities

In Canada only 109 hospitals of those submitting annual returns to the federal Department of National Health and Welfare in 1960 for hospital insurance purposes, reported Social Service Departments. These departments had a total staff of 290 full-time and 34 part-time workers, to serve a total bed capacity of approximately 46,000. This gives an average of one full-time worker (or the equivalent) for 150 beds in these hospitals, — a poor measurement of caseload because of variations in out-patient service, which are not available.

Of these 324 workers (part and full-time), 257 were listed as having the accepted qualifications for professional social work practice, and 67 lacked professional qualifications.

Thirty-seven of the hospitals, with 15,250 beds and 156 social workers, were in the province of Quebec; 28 of the hospitals, with about 14,500 beds and 71 workers were in Ontario; the remaining 44 hospitals, scattered through every province except Prince Edward Island, have 97 workers, serving 15,900 beds. Department of Veterans Affairs Hospitals included in hospital insurance, are counted in these figures.

Similar figures for mental hospitals and clinics are not available. It is probable that social service departments are more numerous, although it is doubtful that the proportion of workers to beds would be greater.

Social workers maintain that a social service department is a very important part of a hospital. The hospital standards of the American Hospital Accreditation Commission require such a department for accreditation as a Grade A hospital. Canada has not set this as a requirement.

No standard figure can be given of the number of social workers needed to give adequate professional service to a hospital. This varies with such factors as the type of hospital, its location, the proportion of in-patient to out-patient services, the policy regarding referral of private patients to the social service department, etc. It is obvious, however, that, if it is accepted that social workers have an important contribution to make to medical care, that all hospitals should have social service departments or, if the hospital is too small for this, should have some arrangement for the part-time services of a social worker. This could be organized regionally with the social workers attached to a county health unit, or be provided by community social agencies. Hospital Insurance Commissions or Departments should provide a consultant in social work to encourage and help the participating hospitals to develop this type of professional service.

In view of the shortage of social workers and the extent of the need, in many cases recognized, by the hospitals, we take the view that an increase in the supply of social workers is essential for the effective provision of medical care.

We recommend that the Royal Commission recognize that :

i) a Social Service Department is an essential part of a hospital or medical treatment institution, whenever that institution is sufficiently large to support the service;

ii) to give effective service, such Departments should be staffed by professionally qualified social workers;

iii) the appointment of social workers to county health units should be encouraged to supply professional service in small hospitals, to assist with the social problems of ill people in their own homes, and to facilitate the movement of persons to and from medical centres when this is necessary;

iv) many patients receiving medical care from private practitioners do not have available to them, the services of professional social workers, and as social problems related to illness are not confined to persons requiring hospital or institutional treatment, the medical practitioners should be encouraged to make use of social workers attached to public and private community agencies when their patients need the help of a social worker.

II. The Interdependence of Health and Welfare Services

Adequate health care is dependent upon the provision and co-ordination of appropriate welfare services. The lack of such services may create stresses which endanger health; the lack of co-ordination may limit or negate the usefulness of the medical care program.

Good health and the freedom from fear of the economic and social consequences of sickness or disability enable a person to use his mental and physical resources for personal achievement and self-fulfilment, and consequently for the strengthening of family and community life. Illness, even among those usually healthy, can be a potent factor in personal and family disorganization. The prevalence of social, economic and psychological disability among the chronically ill and physically disabled runs very high.

Medical advice is ineffective if the patient has not the means, and in many cases the individualized help, necessary to carry out the prescription. "Prescriptions" include not only diet, drugs, nursing care, institutional care, appliances and equipment, but living conditions, rest, vocational rehabilitation, freedom from financial worry, freedom from worry about home responsibilities abdicated during illness. Health services can well be dissipated when the patient has no means of carrying out the prescription, or is impeded from doing so because of his uncertainties about the effect upon himself and his family. He may, for example, return to work before he is ready, because of his financial worries; or he may refuse to accept "charity" because of the stigma he feels is attached to it.

Certain community welfare services are frequently related to health care, and may be needed by any patient or his family, regardless of their economic status. Examples of these follow :

1. Supportive social services to the patient and his family, who often lack the capacity to cope with a multiplicity of problems tripped off by illness, may enable the patient to make appropriate use of the physician's prescription for a social regime. In their absence he may be unable to follow the instructions of the doctor, hospital or rehabilitation service during his convalescence because of demands made on him at home or at work. Unresolved social problems caused or aggravated by his illness may seriously impede his recovery despite the best possible medical care. Social problems related to illness are not uncommon, and are illustrated by : the stigma attached by the community to a particular diagnosis, such as mental illness; the pervasive fear associated with some illnesses, such as cancer; the patient's over-whelming concern for his family during his absence from home or work while receiving treatment; his anxiety or guilt over the dislocation that his illness or disability is causing his family; the mother's sacrifice of herself for her family, etc.

   Where the patient is a member of a family, the entire family becomes involved in his illness and the medical treatment plan. He may not be able to accept the treatment prescribed without his family's support; they may not be able to accept his illness and help him recover from it without help with the stresses created for them. The impact of the illness may be highly disruptive to family life and demand difficult adjustments from both the patient and other members of the family. The health of the entire family may be threatened.

   Income maintenance and family counselling services are essential for effective health care.

2. Modern methods in medical treatment, the shortage of hospital beds and the high cost of hospital care all result in earlier discharge. Loss of income due to illness and the absence or inadequacy of welfare assistance for family maintenance may rob the breadwinner, mother or housewife, of a much needed period of convalescence. Or adequate home-care facilities may render hospital care unnecessary.

   Homemaker service may be vitally important to insure that the convalescent is not forced too quickly to assume his normal task. This is particularly true in the case of mothers who are hospitalized or ill at home, and unable to provide the care for their children except at serious risk to their own health. Yet vital though this service is, very few Canadian communities provide it for their residents, and even in those communities

which have Homemaker Services, the demand characteristically outruns the ability to meet them. Home-care programs, in which there is a growing interest, involves a team approach to meet the needs of the patient in his home, and the social worker is an important member of the team. The ability of the patient to remain at home may depend upon the availability of welfare services, to help provide the conditions essential for his care, and to work with the family regarding the adjustments which are necessary.

For some patients ready for discharge from hospital, a "half-way house", foster-home or convalescent home is most appropriate. Since active medical treatment is often not necessary, or may be given as an "out-patient" service, such forms of care are generally regarded as a welfare responsibility rather than a health service; regardless of the auspices of appropriate care during convalescence, such care is an essential part of a comprehensive health care program.

3. Many of the problems mentioned above are emphasized when a patient has no family, or no family located within the area in which he should remain until he is discharged from medical supervision. Hospitals have always been concerned about the patient, ready for discharge but not yet able to assume full responsibility for his own care, who is likely to continue in hospital because he has no family to make plans for him, or to assume his care; while social workers in the hospital can facilitate his discharge if there are community services available, the inadequacy of such services in many communities creates a very difficult situation. Delay affects the patient's recovery, and of course increases the costs of hospital care.

4. People often require help in seeking the health care they need, both preventive and remedial. For example, child welfare workers frequently find children suffering from the lack of proper medical, dental and other types of health care; suffering from malnutrition, needing corrective shoes or glasses, and living with uncorrected congenital or acquired crippling conditions. Social workers in all types of agencies have an important case-finding function for the health services. Their service is also frequently required to help people make use of the health care they require.

Certain welfare services have particular importance for special groups of Canadians :

1. **Persons who are dependent upon public assistance** for their maintenance often fail to receive full health care, although poor health may be a contributing factor to their financial dependence. Although some provision is made for the cost of drugs, prosthetic appliances, special diets, etc., under welfare departments for the recipients of public assistance, the provision varies greatly not only from province to province, but from municipality to municipality, and is in many ways inadequate and uncoordinated with medical care. These health needs are regarded as exceptional within the welfare program, and their provision may therefore be outside the regular administrative procedures. Although the need is often very urgent, their provision is often delayed and complicated so that they are not readily accessible.

The way in which medical care is provided to the indigent deters many recipients from seeking it except in acute emergencies. In some communities, patients must "shop around" for a doctor willing to care for them. Provision for the costs of transportation to the clinic or medical centre, or for the care of children while a mother attends clinic for herself or for an ailing child, is often not considered by welfare department, and must be met by the recipient from a very minimal budget. It follows that preventive and restorative health services essential to a comprehensive health program are not in reality available to the indigent.

2. **The medically indigent** are generally defined as the low-paid workers (and their dependents) who are able to finance independently the day-to-day costs of living, but whose budgets do not permit any emergency expenditure. They also include however, the more highly paid workers with large families: in fact any family may become medically indigent when a serious illness strikes the breadwinner, or when costly or long medical treatment is required by one or several of its members. With the rising cost of medical care, an increasing number of Canadians are medically indigent. Even those covered by pre-payment medical care plans cannot finance the cost of the prescribed treatment or other medical costs not covered by the plans, and may seek social agencies for their purpose. Costly items such as eye-glasses, dental work, hearing aids, and other appliances and equipment are often less available to low-income workers and their families than to persons receiving public assistance. Lack of provision in our social security program for loss of wages due to illness further aggravates the situation of the medically indigent. The pressure in our society to live at the highest standard of living possible means that the budgets of

large sections of the community do not allow for the extraordinary costs of medical care and treatment.

The inability of the medically indigent to obtain adequate health services often precipitates social problems. This is particularly true in families where there are limited occupational skills, based on low educational achievement, or associated with emotional and social difficulties. These are the families beset by many problems, for whom illness or disability is one additional and sometimes overwhelming burden. But few families avoid entirely the socially disabling effect of poor health. Family counselling services, under public or private auspices, are essential if these families are to be able to function effectively in our communities.

3. The care of **the chronically ill and the infirm aged** causes considerable difficulty through the present division of responsibility between the health and welfare departments. The problems have been emphasized since the development of hospital insurance, and the rigid differentiation between hospitals and welfare institutions. People in these groups often need active medical care and domiciliary care in quick succession, in many cases preferably within the same institution, which is very difficult with the division of welfare and health responsibility. Admittedly this is a complex problem, but it requires urgent attention. Administrative arrangements should enable the provision of the care appropriate for each sick person.

Facilities for chronic and convalescent care are generally inadequate for the need. Such institutions are usually classified as "welfare" yet the appropriate use of health facilities depends upon their adequacy.

In our opinion the solution lies in close co-operation between health and welfare departments, rather than rigid separation of function and responsibility.

4. **The population of rural or remote areas** face other problems. Appropriate medical care often means travel to a medical centre, and the expense of transportation and of living accommodation when the patient does not require hospital care but needs to remain accessible to the medical centre. Transportation and living expenses may be beyond the ability of the person to pay; finding his own accommodation when he is sick and does not know the community may be beyond his capacity. People who do not live near medical facilities should have the opportunity to make use of the health services, and can only do so if financial and other assistance is provided. This means payment

and arrangements for transportation, and the provision of boarding house or hostel care in such centres.

5. **The rehabilitation of the handicapped** is another area in which health and welfare services must be closely co-ordinated if they are to be effective. Disability due to congenital defect, accident or disease has blighted the lives of thousands of persons and removed them at least partially from the productive stream of life. The great stimulus to rehabilitation services in Canada as elsewhere came from the post-war efforts to restore veterans to a useful place in society. Public provision of the needed diagnostic, assessment, treatment, training and placement services were extended as a matter of right to the war-injured and disabled. In most provinces some rehabilitation services are also available to the industrially injured through Workmen's Compensation. Since the recognition by the federal government of the need in this area, commendable progress has been made in civilian rehabilitation. A great deal remains to be done.

Here, coordination between health, education, employment and welfare services is essential, and particularly difficult since the services needed by one patient are provided under a wide variety of auspices, both public and private.

Because the effects of disability are complex and far-reaching, services to restore disabled persons to useful and productive lives must be designed to take into consideration all the varied needs of the disabled. In the absence of a co-ordinated approach, many handicapped persons may receive the best of medical and surgical treatment, yet remain discouraged, dependent persons who will carry the burdens of psychological, social or vocational disability long after their physical or mental handicap has been treated.

We therefore recommend that the Commission recognize that:

i) a national health program will be limited in its effectiveness unless the supporting welfare services are also strengthened. This means the development of new services, in some instances, such as the provision for loss of income due to illness of the breadwinner; in other instances, it means the expansion of services now available in some communities to other areas, or their expansion within a community to make adequate provision: for example, convalescent hospitals, homemaker services, or the provision of prosthetic appliances.

ii) the close co-ordination of health and welfare services is necessary if the provision of medical care is to be effective in developing a physically and mentally healthy population;

iii) the pattern of services must be dictated by varied needs of sick people, and not be compartmentalized for the sake of apparent administrative simplicity.

III. A National Program for Personal Health Care

Social workers support the democratic philosophy that every person should have the opportunity to develop to his full potential, and to make his most effective contribution as a member of society. We agree that physical and mental health is desirable and that all people suffering from ill-health should have the opportunity for the medical care appropriate to their physical and mental conditions. We know that good health is costly, but we consider that the poor health of its people is even more costly to society. We do not approve of the provision of health care through a program which divides the nation into first class and second class citizens on the basis of their ability to pay individually for the medical care they need.

We maintain therefore that society has the responsibility of ensuring that the opportunity for adequate health care is provided to is members.

In their professional practice in Canada, social workers often meet people who show the results of inadequate or postponed medical care. Such people come to social agencies with social problems: family conflict aggravated by heavy debts; children needing protection or care outside their own homes; children and adults seeking medical care for conditions which have been aggravated by delay or neglect.

We are aware that various facilities now provide pre-payment plans; that doctors give free care; that in many communities clinics are available at low cost; that medical care is in varying degrees provided for the recipients of public assistance, or for the medically indigent. Yet we know from our experience that many people are not receiving the medical care they need. In the term medical care, we include the wide scope of preventive, remedial and curative health services for physical and mental illness and disability.

We realize that some people do not take advantage of the facilities available to them. Sometimes this is due to ignorance or fear: fear of the diagnosis or of the anticipated cost. Sometimes it is due to the conditions under which the medical care is available. Other people, particularly in rural areas, do not have accessible facilities.

Private pre-payment plans generally are available only to those who are steadily employed and their dependents. Even for those covered, the

plans are not generally comprehensive: they exclude various conditions and types of care, or limit the amount of care provided. They help those whom they include but they do not make medical care available to all who need it.

Persons who cannot pay for their care should not be dependent upon the free service given by doctors. We consider they have a right to the medical care they need, and should not be dependent upon the charity of the medical profession. Most people will only seek such charity in a critical situation, and the free service of the doctor does not enable them to carry out his instructions.

Out-patient clinics, where they exist, provide a valuable service, perhaps particularly where specialist consultation is required. But many clinics involve long hours of waiting, difficult for the person who must take time off from work, or for the mother who has children to care for; depressing and even debilitating to the sick person in search of health. Clinics have difficulty also in organizing continuity of professional service, to ensure that the patient sees the same doctor each time.

Our members support the establishment of a plan to provide comprehensive health services. We are of the opinion that such a plan should include everyone living in Canada. If it is to be provincially administered, it should cover people fully if they move from one part of the country to another.

The health services made available under such a plan should be related solely to the health needs of the individual patient, regardless of his financial need, or such things as residence or citizenship. The services should be provided in a manner which recognizes the person's inherent right to self-respect, privacy and dignity. There should be no difference in the kind, quality or form of care available under the plan based on the ability of the patient to pay. That is, one plan should provide for all, whether payment is made by the individual or by the government on his behalf (if an individual premium is expected). While everyone should be covered by the plan, people should be free to make their own arrangements outside the plan, if they so desire.

In our opinion, the best way of securing universal coverage is a government-administered plan financed from taxes. We are convinced that a tax-supported plan is the only way of securing universal coverage and that it is vastly simpler and cheaper to administer. It would make a means test unnecessary, as the payment of premiums would demand; it would draw no distinction between people who paid their own premiums and those for whom government would need to pay, and hence would avoid the possibility of stigma or differential treatment. We question the argument that individual payment has a deterrent psychological effect, or

that the individual does not realize that he is paying through taxes. Compulsory premiums are indistinguishable from taxes, and cannot be adjusted to the ability to pay.

We are also opposed to deterrent payments or co-insurance. These will only affect people whose incomes are marginal, and in many cases they would need financial assistance from some source, public or private, to make such payments. The effect of such deterrents on utilization of care, too, is questioned.

We recognize that if the plan is administered provincially, flexibility in the method of financing may be necessary, as in hospital insurance. We would hope that such flexibility might be regarded as a stage in development towards the goal of a tax-supported program.

We recognize that the plan we support will be a costly one. We point out that adequate medical care is costly, and that this is one of the main reasons that it is not now available to all who need it. The costs of medical care are likely under the present system, to fall most heavily on those least able to pay. The total cost of a public program however will not all be "extra" cost, for Canadians are now paying large sums for medical care and part at least of this amount would merely be paid into other channels. The increased cost will in large part be the payment for the care now needed but not obtained. Since we insist that all people should have the medical care they need, we see no alternative to the cost. We recognize that there will be administrative expenses, and that there may be some abuse.

We repeat however, that ill-health is more costly to the nation than a health program would be.

The figures of the savings effected by rehabilitation services, through which disabled persons, previously dependent, have been enabled to make their contribution to the economy of the country and to become, with their families, completely independent, demonstrate that the expenditure for health care is likely to bring to the country more than compensating monetary returns.

Canada is a wealthy country, and much poorer countries have been able to afford medical care plans. Basically the question of whether we can "afford" comprehensive health care depends upon the strength of our desire for it: it is a question of priorities, not only in governmental but in personal expenditure.

If a comprehensive health plan is launched under government auspices, its administration, while leaving medical decisions to the medical profession, should allow for the active participation in policy-making of the citizens of the country. The consumers of health care have a right to be represented in the administrative body.

We therefore recommend to the Commission that:

i) the government should establish a program to make available to all persons living in Canada, comprehensive health services;

ii) the program be financed by taxes;

iii) the services be available to all persons domiciled in Canada without distinction;

iv) the plan be administered in such a way as to provide adequate citizen participation in the policy-making body;

v) the plan not to include deterrent payments or co-insurance.

IV. The Shortage of Social Workers

The Commission has a particular interest in the availability of health personnel. Social workers are in very short supply. Our recommendations would require a great increase in the numbers employed, not only giving professional service within the health care facilities but also in the supporting welfare services. The need for professional personnel in all social services is very great and no priorities can be established between them. Not only is the need, as seen by social workers, great but the present demand far exceeds the supply.

We see no purpose in trying to estimate numbers, as we are unable to conceive of the requirements being fully met. Our profession is competing with many others for the available men and women who graduate from our Universities.

An outline of the requirements of professional education is included in the Appendix to this submission. The accepted qualification for admission to the profession is a Master of Social Work, awarded after the satisfactory completion of two years of professional education in an accredited school of social work, for which the academic admission requirement is the Bachelor of Arts. This involves five or six years of University work, and hence is costly to the student and to the Universities.

In June 1960, the professional association passed a resolution asking the Federal government to establish welfare training grants to enable more students to undertake professional training in social work. This resolution, forwarded to the federal Minister of Health and Welfare, appears in the Appendix. It has been supported strongly by the Canadian Welfare Council. We do not consider it necessary to add to these representations.

We therefore recommend that the Commission:

add its support to the representations already made to the federal government, that welfare training grants be made available to

assist students to undertake professional training in social work, and to extend the facilities of the Schools to enable them to increase their enrolment.

(NOTE — In presenting the brief to the Royal Commission on May 28, 1962, the President made reference to the announcement of the Minister of Health and Welfare, in relation to a program of Welfare Training Grants)

Appendix I

CANADIAN ASSOCIATION OF SOCIAL WORKERS
ASSOCIATION CANADIENNE DES TRAVAILLEURS SOCIAUX

Founded: 1926

Incorporated 1956, under the Dominion Companies Act

Objects:

(a) to promote, develop and sponsor activities appropriate to the strengthening and unification of the social work profession;

(b) to encourage and assist in the development of high professional standards amongst its members;

(c) to promote the well-being and development of its members as professional people;

(d) to provide a means whereby the Corporation through its members may take action on issues of social welfare;

(e) to edit and publish books, papers, journals and other forms of literature respecting social work in order to disseminate information to members of the Corporation as well as to members of the public;

(f) to encourage specialized studies in social work amongst its members and to provide assistance and facilities for special studies and research;

(g) to carry on such other activities in relation to the foregoing as may be deemed advisable.

Membership:

The membership of the Association is composed of men and women, 2681 in all.

The minimum qualification for membership at the present time is the successful completion of at least one year of professional social work education in a recognized graduate school of Social Work.

In January 1964, this requirement will be raised to two years of professional social work education in a recognized graduate School of Social Work. Exceptions are made in cases where social workers received social work training in recognized schools or departments of social work in other countries, after a period of satisfactory service in Canada.

Types of Employment:

Government of Canada

Department of National Health and Welfare
. . . mental health services, medical rehabilitation, Indian Health Health Service, public assistance, family allowances and old age security, emergency welfare services, research division.

Department of Veterans Affairs
. . . treatment services (D.V.A. hospitals across Canada), welfare services.

Department of Justice — prison and parole services.

Department of Citizenship and Immigration — liaison officers in immigration services; welfare services in Indian Affairs.

Department of Northern Resources
. . . welfare services including problems arising regarding illness.

Department of Labour — rehabilitation section.

Provincial Governments :

Department of Public Welfare

Department of Child Welfare

Department of Health — mental hospitals and clinics

Department of Corrections — institutions and probation services.

Municipal Government :

A few municipal departments of welfare
General Hospitals, Hospitals for Children, some municipal health departments; a few Boards of Education; Juvenile and Family Courts.

National Voluntary Agencies :

. . . such as Canadian Welfare Council, Canadian National Institute for the Blind (with its provincial and local branches), Canadian Mental Health Association (particularly in regional areas), Canadian Arthritis and Rheumatism Society (local areas), Salvation Army, etc.

Local Voluntary or semi-public services :

. . . family welfare agencies, child welfare agencies, child caring institutions, homemaker services, youth serving agencies (Big Brother Movement, Big Sister Association, Y's, Boy Scouts), settlement houses, neighbourhood centres, welfare councils, community chests, prisoners' aid societies.

Publications :

The official journal *The Social Worker — Le Travailleur Social* is published quarterly.

. . . Statement of Standards to be Met by Medical and Psychiatric Social Service Departments in Hospitals, Clinics and Sanatoria

. . . The Profession of Social Work (English and French)

. . . Reports published biennially re Association Program

. . . Other special reports published from time to time.

CANADIAN ASSOCIATION OF SOCIAL WORKERS

Appendix II

Social Work Education

"Social work practice, like the practice of all professions, is recognized by a constellation of values, purpose, sanction, knowledge and method. No part alone is characteristic of social work practice nor is any part . . . unique to social work. It is the particular content and configuration of this constellation which makes it social work practice and distinguishes it from the practice of other professions."[1] Social work is a new profession, developing its own body of knowledge and skill in a form which can be taught through professional education only within the last fifty years. It is a profession which, — because of the acceptance of a degree of responsibility by men for the welfare of their fellows, and by society for the welfare of its members; because the increasing complexity of life has increased the interdependence of people, and created problems which even 'strong' men cannot solve for themselves; because the growing knowledge of the social sciences and of social work itself have made available the knowledge of how to help, in ways which are constructive both to men and to society; — has developed very rapidly, but not sufficiently so to meet the ever-increasing demand for its services.

In Canada and in the United States of America, the basic education for the profession of social work is two years of professional education at the post-graduate level leading to a Master's degree. There are eight schools in Canada, seven of which are accredited by the Council on Social Work Education, of which the Accrediting Commission sets and assesses the standards of both Canadian and American schools.

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[1] Commission on Social Work Practice. *Working Definition of Social Work Practice.* New York: National Association of Social Workers, 1958.

Admission is granted to students who have the B.A. or an equivalent degree, with a strong core of undergraduate work in the social sciences, and who are considered to have the personal qualities and attitudes which will enable them to become competent practitioners. The two years are planned as an integrated program of full-time study, in which the student receives class-room instruction in human growth and development, the social services and the theory of practice; is placed for field instruction in a social agency or department (under public or private auspices) under the supervision of an instructor selected by the school, to develop beginning skill in practice, using the knowledge learned in the class-room; and completes a research project. The curriculum is designed to teach him to understand the behaviour of people, particularly people under stress; the organization of society in which he lives; and the ways of helping both people and society function more adequately in relation to each other. The school seeks to help him acquire the knowledge, attitudes and skills necessary to enable him to begin professional practice: to enable him to give help to people with social problems so they are more able to function independently; to help people in the normal process of living to learn to live amicably with their fellow-men; and to contribute leadership in community planning, social policy formulation, research and administration in the development of a society which promotes the well-being of its members.

In the practice of social work, five social work methods are identified of which each student must choose his preference: case work, in which the social worker develops particular competence in helping in a one-to-one relationship; group work, in which he works with a small group, using the interaction of the group members as part of the helping process; community organization work, in which the people with whom he works are members of the community who seek to improve the welfare of the community; and administration and research, the processes which underlie the effective provision of community services.

The theory of practice of each method is generic, although the practitioner may use his skill in a particular type of setting. Hence the student who wishes to prepare for social work in a hospital will learn the same knowledge and skills as other social workers, and must learn to adapt his use of the skills in the hospital in which he practices. He may have his field instruction in a hospital or other health-oriented agency; or he may make the choice of this setting for employment after graduation. In any setting he must learn the specifics as part of his orientation to the position he has taken; if his basic training has been sound, he should have no great difficulty in acquiring the additional knowledge and adapting his skill to a health agency. As in all professions, it is desirable that he work under a more experienced practitioner when he first enters the profession.

The eight Schools of Social Work in Canada are listed below. In the academic year 1960-61, they graduated about 160 students with Master's degrees in Social Work. As of November 1, 1961, there are about 560 full-time students enrolled in these schools, 340 of them in the first year.

School of Social Work,
University of British Columbia,
Vancouver, B.C.

School of Social Work,
University of Manitoba,
Winnipeg, Manitoba.

School of Social Work,
University of Toronto,
273 Bloor Street West,
Toronto, Ontario.

School of Social Welfare,
St. Patrick's College,
University of Ottawa,
Ottawa, Ontario.

School of Social Work,
McGill University,
3600 University Street,
Montréal, P.Q.

Ecole de Service Social,
Université de Montréal,
Boulevard Mont-Royal,
Montréal, P.Q.

Ecole de Service Social,
Université Laval,
Québec, P.Q.

Maritime School of Social Work,
6414 Coburg Road,
Halifax, Nova Scotia.

Resolution re : Welfare Training Grants

adopted by biennial meeting

Canadian Association of Social Workers — June 1960

WHEREAS the federal health grants program has proved successful for the training and employment of social workers in the mental health field; and

WHEREAS the provincial governments have made use of these grants to provide bursaries for interested and eligible students to pursue post graduate studies in the field of social work; and

WHEREAS the mental health services in Canada have been strengthened and expanded as a result of this program; and

WHEREAS there is great need for professional help in executing a general welfare program which cannot be met by existing staffs in the welfare field,

THEREFORE BE IT RESOLVED that C.A.S.W. petition Her Majesty's Government of the Dominion of Canada to establish a project, and make funds available to all provinces (following the pattern of the federal health grants) for professional training designed to provide additional personnel in the general welfare field.

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